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Prior Authorization Request Administrative Information

Member information

Last name _____ First name _____ MI _____

Member ID _____ Date of birth _____

Sex assigned at birth ☐ Female ☐ Male ☐ "X" or Intersex

Current gender ☐ Female ☐ Male ☐ Transgender male ☐ Transgender female ☐ Other _____

Place of residence ☐ Home ☐ Nursing facility ☐ Other _____

Race _____ Ethnicity _____

Preferred spoken language _____ Preferred written language _____

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, Children's Medical Security Plan, and Health Safety Net Plan
☐ **MassHealth Drug Utilization Review Program** Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318
MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)
☐ **Fallon Health** Online Prior Authorization: go.covermymeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
☐ **Health New England** Online Prior Authorization: go.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
☐ **Mass General Brigham Health Plan** Online Prior Authorization (Non-Specialty Drugs): go.covermymeds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
☐ **Tufts Health Plan** Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
☐ **WellSense Health Plan** Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

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Pediatric Behavioral Health Medication Initiative
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

The **Pediatric Behavioral Health Medication Initiative** requires prior authorization for pediatric members (generally members < 18 years of age) for certain behavioral health medication classes and/or specific medication combinations (i.e. polypharmacy) that have limited evidence for safety and efficacy in the pediatric population. For a comprehensive medication list and additional information about the **Pediatric Behavioral Health Medication Initiative**, including PA requirements and preferred products please refer to the MassHealth Drug List at **www.mass.gov/druglist.**

Please refer to the following table for guidance on filling out this PA form.
Complete Section I, and all pertinent Sections as described below.

For all requests, complete Section I in its entirety.	
Next, please complete all pertinent Sections as described below.	
Polypharmacy Request Within the Same Medication Class [e.g., regimen includes more than one antidepressant, benzodiazepine, cerebral stimulant, mood stabilizer (agents considered to be used only for seizure diagnoses are not included)]	Section II
Antipsychotic Polypharmacy Request	Section III
Behavioral Health Medication Request for Members < six years of age [e.g., antidepressant, armodafinil, atomoxetine, benzodiazepine, buspirone, donepezil, memantine, meprobamate, modafinil, mood stabilizer (agents considered to be used only for seizure diagnoses are not included), naltrexone, prazosin, viloxazine, or xanomeline/trospium]	Section IV
Antipsychotic Request for Members < ten years of age	Section V
Alpha$_2$ Agonist or Cerebral Stimulant Request for Members < three years of age	Section VI
Hypnotic Request for Members < six years of age	Section VII
Request for Members on Multiple Behavioral Health Medications	Section VIII
Request for Non-Preferred Drug Products	Section IX
Request for Exceptions to Step Therapy	Section X

Thank you for helping to ensure that MassHealth pediatric members receive medically necessary behavioral health medications that are safe, effective, and optimize patient care.

Medication information

Section I. Please complete for all requests for medications subject to the Pediatric Behavioral Health Medication Initiative for members < 18 years of age.

Please document complete treatment plan listing all requested agents (include all behavioral health agents, corresponding strength, dose, directions of use and indication(s) or ICD-10 code(s), if applicable, for each medication(s)).

1. Medication name Dose/frequency Indication
2. Medication name Dose/frequency Indication
3. Medication name Dose/frequency Indication
4. Medication name Dose/frequency Indication
5. Medication name Dose/frequency Indication
6. Medication name Dose/frequency Indication
7. Other(s)

Is the member currently in an acute care setting?

☐ Yes. (Inpatient) ☐ Yes. (Community Based Acute Treatment) ☐ Yes. (Partial Hospitalization) ☐ No

For members who are in an acute care setting, please document the outpatient prescriber after discharge.

Prescriber name Contact information

Has the member been hospitalized for a psychiatric condition within the past three months?

☐ Yes. Please document dates of hospitalization within the past three months. ☐ No

On the current regimen, is the member considered to be a severe risk of harm to self or others?

☐ Yes. Please provide details. ☐ No

For regimens including an antipsychotic, are appropriate safety screenings and monitoring being conducted (e.g., weight, metabolic, movement disorder, cardiovascular, and prolactin-related effects)?

☐ Yes ☐ No. Please explain.

Has informed consent from a parent or legal guardian been obtained?* ☐ Yes ☐ No

Please indicate prescriber specialty below.

☐ Psychiatry ☐ Neurology ☐ Other

☐ Specialist consult details (if the prescriber submitting the request is not a specialist)

Name(s) of the specialist(s) Date(s) of last visit or consult

Contact information

For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician, if applicable.

Please document member custody status.

☐ Parent/Guardian ☐ Department of Children and Families (DCF)

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Please document member placement status.

☐ Home with Parent/Guardian ☐ Foster Care ☐ Residential Treatment Facility

☐ Uncertain ☐ Other

Please document agency involvement.

☐ DCF ☐ Department of Mental Health (DMH)

☐ Department of Developmental Services (DDS) ☐ Department of Youth Services (DYS)

Is the member/family currently receiving appropriate psychotherapeutic and/or community based services for the targeted clinical mental health related concerns (e.g., Applied Behavioral Analysis, Children's Behavioral Health Initiative, school interventions, specialized placement)?

☐ Yes. Please document details of interventions below, if applicable. ☐ No

Psychiatric care provided is coordinated with other psychotherapeutic and community based services. ☐ Yes ☐ No

Is this member a referral candidate for care coordination? ☐ Yes ☐ No

If yes, MassHealth will offer this member care coordination services. Please describe which additional behavioral health services would be beneficial. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

** Sample informed consent form available on the MassHealth PBHMI Information webpage. For additional information go to: https://www.mass.gov/info-details/pediatric-behavioral-health-medication-initiative-pbhmi-information*

Please complete for members who have been on one of the following for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation): a polypharmacy regimen, members < six years of age who have been on an applicable behavioral health medication, and members < ten years of age who have been on an antipsychotic.

Have previous efforts to reduce or simplify the regimen in the past 24 months resulted in symptom exacerbation? ☐ Yes ☐ No

The family or caregiver does not support the regimen change at this time due to risk of exacerbation. ☐ Yes ☐ No

Is there another significant barrier for therapy discontinuation? ☐ Yes ☐ No

If yes, please explain.

Section II. Polypharmacy within the same medication class (e.g., antidepressants, benzodiazepines, cerebral stimulants, mood stabilizers [agents considered to be used only for seizure diagnoses are not included]). Complete this section for all members < 18 years of age if request will result in polypharmacy within the same medication class.

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) were tried before prescribing polypharmacy with two or more agents within the same medication class for this member.**

Drug name Dates/duration of use

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

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Drug name Dates/duration of use

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

Other(s)

Please document clinical rationale for polypharmacy within the same medication class for this member.

Please document the treatment plans for medication regimen simplification (e.g., dose consolidation, frequency reduction) or medical necessity for continuation of a complex medication regimen.

Has the member been on an antidepressant or mood stabilizer polypharmacy regimen for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)?

☐ Yes. Please complete the applicable question in Section I. ☐ No

***Attach a letter with additional information regarding medication trials as applicable.*

Section III. Antipsychotic Polypharmacy. Complete this section for all members < 18 years of age if request will result in prescription of two or more antipsychotics for ≥ 60 days within a 90-day period.

Please select the stage of treatment and clinical rationale for antipsychotic polypharmacy.

☐ **Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)

☐ Member experienced an inadequate response or adverse reaction to two monotherapy trials with antipsychotics.

Drug name 1 Dates/Duration of use

Drug name 2 Dates/Duration of use

☐ Member is transitioning from one antipsychotic to the other.

☐ Other, please explain.

☐ **Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)

1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?
   ☐ Yes ☐ No
2. Has the member been on an antipsychotic polypharmacy regimen for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)?
   ☐ Yes. Please complete the applicable question in Section I. ☐ No

☐ **Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)

☐ Member is transitioning from one antipsychotic to the other.

☐ Member is tapering antipsychotic. Please describe taper plan including duration.

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Section IV. Behavioral Health Medication (e.g., antidepressant, armodafinil, atomoxetine, benzodiazepine, buspirone, donepezil, memantine, meprobamate, modafinil, moodstabilizer [agents considered to be used only for seizure diagnoses are not included], naltrexone, prazosin, viloxazine, or xanomeline/trospium) for members < six years of age.

Please document any previous medication trial(s). Include drug name, dates/duration of use, and outcome.**

Please document clinical rationale for use of an antidepressant, armodafinil, atomoxetine, benzodiazepine, buspirone, donepezil, memantine, meprobamate, modafinil, mood stabilizer, naltrexone, prazosin, or viloxazine for this member < six years of age.

Has the member been on the requested agent for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)? ☐ Yes. Please complete the applicable question in Section I. ☐ No

***Attach a letter with additional information regarding medication trials as applicable.*

Section V. Antipsychotic Request for Members < ten years of age.

Please select the stage of treatment and clinical rationale for use of an antipsychotic for this member < ten years of age.

☐ **Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)

☐ **Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)

1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?
   ☐ Yes ☐ No
2. Has the member been on an antipsychotic agent for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)?
   ☐ Yes. Please complete the applicable question in Section I. ☐ No

☐ **Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)

☐ Member is transitioning from one antipsychotic to the other.

☐ Member is tapering antipsychotic. Please describe taper plan including duration.

Section VI. Alpha$_2$ Agonist or Cerebral Stimulant Request for Members < three years of age.

Please document any previous medication trial(s). Include drug name, dates/duration of use, and outcome. For requests for an amphetamine product, include drug name, dates/duration of use, and outcome to a trial with a methylphenidate product.**

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Please document clinical rationale for use of an alpha2 agonist and/or cerebral stimulant for this member < three years of age.

***Attach a letter with additional information regarding medication trials as applicable.*

Section VII. Hypnotic Request for Members < six years of age.

Please document if member has other behavioral health comorbidities (e.g., anxiety, depression, ADHD).

Please document medication trials with melatonin and/or clonidine, if clinically appropriate. Include drug name, dates/duration of use, and outcome.**

Please document behavioral interventions (e.g., bedtime routine, extinction, fading, strategic napping, positive reinforcement, regular sleep-wake cycles, sleep restrictions, relaxation techniques).

Please document clinical rationale for the use of a hypnotic agent for this member < six years of age.

Has the member been on the requested hypnotic agent for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)? ☐ Yes. Please complete the applicable question in Section I. ☐ No

***Attach a letter with additional information regarding medication trials as applicable.*

Section VIII. Multiple Behavioral Health Medications.

Complete this section for all members < 18 years of age if request will result in prescriptions of four or more behavioral health medications within a 45-day period if one of the following is included: an antipsychotic, a benzodiazepine, divalproex/valproate, lithium, or a tricyclic antidepressant.

Also complete this section for all members < 18 years of age if request will result in prescriptions of five or more behavioral health medications within a 45-day period. For a complete list of all behavioral health medications, please refer to the MassHealth Pediatric Behavioral Health Medication Initiative.

Please document monotherapy trials (include drug name, dates/duration of use, and outcome) tried before prescribing a polypharmacy regimen for this member.**

Please document clinical rationale for use of multiple behavioral health medications for this member < 18 years of age.

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Please document the treatment plans for medication regimen simplification (e.g., dose consolidation, frequency reduction) or medical necessity for continuation of a complex medication regimen.

Has the member been on the requested polypharmacy regimen for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)? ☐ Yes. Please complete the applicable question in Section I. ☐ No

***Attach a letter with additional information regarding medication trials as applicable.*

Section IX. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Section X. Please complete and provide documentation for exceptions to step therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member? ☐ Yes ☐ No
   If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?
   ☐ Yes ☐ No
   If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?
   ☐ Yes ☐ No
   If yes, please provide details for the previous trial.
   Drug name Dates/duration of use
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe details of adverse reaction or inadequate response.

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?
   ☐ Yes. Please provide details.
   ☐ No

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Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name* First name* MI

NPI* Individual MH Provider ID

DEA No. Office Contact Name

Address City State Zip

E-mail address

Telephone No.*

Fax No.* (Please provide fax number for PA response notification.)

** Required*

Please also complete for professionally administered medications, if applicable.

Start date End date

Servicing prescriber/facility name ☐ Same as prescribing provider

Servicing provider/facility address

Servicing provider NPI/tax ID No.

Name of billing provider

Billing provider NPI No.

Is this a request for recertification? ☐ Yes ☐ No

CPT code No. of visits J code No. of units

Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

Date

(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)